FORT BRAGG
EPIDEMIOLOGICAL CONSULTATION REPORT

18 October 2002

Chartered by:
U.S. Army Surgeon General

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IMPETUS for the EPIDEMIOLOGICAL CONSULTATION (EPICON):

In a 43-day period during June and July 2002, there was a clustering (grouping of cases in time) of four homicides of spouses of active duty soldiers stationed at Fort Bragg, NC—all cases allegedly perpetrated by the soldiers. Two of these cases also involved completed suicide after the involved soldier murdered the spouse. An additional homicide of an active duty soldier involving the wife as one of the alleged perpetrators also occurred during the same 43-day period.

These five cases generated significant national and international news coverage, and led to various media-reported hypotheses about potential etiological factors that might be involved. Prominent in the media reports were postulated links to the stress of deployment (since three out of the four soldiers had been deployed to Afghanistan), the potential effects of their combat experiences, as well as questions about the impact of potential neuro-psychiatric side effects of the malarial prophylaxis drug mefloquine.

Contemporaneous with the media's increasing awareness of these tragedies, the U.S. Army Office of The Surgeon General (OTSG) established a charter for an epidemiological consultation (EPICON) team composed of Army and Centers for Disease Control subject matter experts to consult with the local medical and line leadership at Fort Bragg. The primary goal of the EPICON was to assess and provide recommendations to OTSG to address potential systemic, cultural, and resource-limitation factors which might be related to the recent apparent clustering of homicides and suicides, as well as deployment-related behavioral health issues.

The EPICON's Charter included four broad goals: 1) Assess the pre- and post-deployment soldier and family education programs, practices, and support/clinical services relative to Service/DoD policies, procedures and requirements, 2) Organize relevant statistical data for comparative analysis, 3) Assess the specific data associated with the index cases looking for patterns, contextual factors, organizational dynamics, and medical issues which may have proximate causal and/or contributing significance, 4) Utilize the data from the index cases as a basis to assess the relevancy and adequacy of the Services' current systemic policies, procedures, and resource requirements.

After coordinating multiple agency collaboration, the EPICON members deployed to Fort Bragg on 26 August and worked for three weeks on site. Interview and focus groups involving soldiers, spouses, leadership, and other agency individuals relevant to the charter's Scope of Activity were conducted. This report summarizes the analysis and results of this U.S. Army OTSG-chartered EPICON effort.

DISCLAIMER:

Three of the five individuals involved in the index cases have been arrested and are pending criminal proceedings under the jurisdiction of local civilian legal authorities. This EPICON was never intended as a legal 'investigation' or to function in such a way as to augment information pertinent to potential civilian criminal prosecution/defense legal processes. As such, the data developed and reported on the three pending legal cases is limited and germane only to responding to the specifics of the EPICON Charter's "Scope of Activity" (Appendix A).

ORGANIZATION OF EPICON REPORT:

For purposes of ready reference by leadership, this report is organized much like a standard medical consultation report with the EPICON's FINDINGS and RECOMMENDATIONS provided initially, followed by a more in-depth discussion of each finding and recommendation with relevant supporting data and pertinent references.

CONTEXT FOR FINDINGS:

These family tragedies clustering at Fort Bragg are of great concern to the entire DoD and DA leadership at all levels. It is important to understand the findings and recommendations that follow to put these tragedies into perspective. Statistical data collected by the U.S. government indicates marital dysfunction and resulting divorce affects approximately 50% of all current marriages. Reported and unreported domestic violence in the context of marital dysfunction is not uncommon. Military marriages have their own unique challenges that are very common within the military services, but much less common in civilian society. These include: 1) frequent and often lengthy service member absences for training and mission deployments; 2) geographic separation of the military family from the couples' families of origin (hence military families do not enjoy the benefit of having extended family available to help support them in times of crisis or spousal separation); 3) demography of the military is relatively young and predominantly male compared to civilian society, hence the prevalence rate of behaviors related to family dysfunction appears higher; 4) most military families reside in local civilian communities surrounding military installations, hence the community dynamics that can either be protective or destructive to family integrity and function are influenced by those community norms and available/unavailable military and civilian community-based support services.

INDEX CASE DEFINITION:

A case definition was established. Index cases were defined as fatal intimate partner violence that involved an Active Duty (AD), Reserve, or National Guard (NG) soldier stationed at Fort Bragg, either as alleged perpetrator (4 cases) or victim (1 case) in June or July 2002. Note that only the four cases involving the soldiers as perpetrators were studied in detail.

FINDINGS:

1. **Statistically Significant Cluster.** The overall homicide rate among soldiers at Fort Bragg over the last 12 months is not significantly different than the national rate. However, the fact that all five of the index cases involved intimate partners, with two of the index cases involving suicide—all clustering in less than two months—is highly unusual, and analyses indicate that these represent statistically significant findings[1]. However, there was no discernible individual epidemiological link between any of the five index cases.

2. **Mefloquine Unlikely Cause of Clustering.** Mefloquine does not explain the clustering. Mefloquine (Lariam) was not prescribed at all for two of the four active duty index cases. The other two index cases did receive prescriptions for mefloquine, but there was no reported history of antecedent changes in personality or unusual behavioral symptoms documented. However, for one of the soldiers who was prescribed mefloquine, definitive determination could not be made about the presence of possible neuro-psychiatric side effects secondary to pending civilian legal actions. Concerns raised regarding mefloquine use by active duty personnel were: 1) reported inconsistency in the screening for psychiatric vulnerability, 2) medical documentation sufficiency, and 3) adequate risk communication during the prescription process.

3. **Marital Discord a Major Factor**. All of the active duty index cases were experiencing marital discord including recent or threatened separation. Two of the three index case-soldiers who had deployed to Afghanistan were returned from the operational theater early to address their marital problems, however they did not access available resources for support. Marital discord at Fort Bragg was a prevalent theme among all focus groups. The lack of TRICARE reimbursement for marital and domestic abuse treatment is an obstacle to assisting distressed military families.

4. **PERSTEMPO Contributor to Marital Discord**. There also exists evidence through focus groups that high operational mission demands requiring time away from home, i.e. PERSTEMPO, may have been a contributing factor, including inadequate time for family re-integration, unpredictable work schedules, and problems with leave management. The possible link between intimate partner violence and deployment experiences is also supported by published literature[2].

5. **Re-deployment Transition Program Execution Challenges.** The tragic events involving the two soldiers who returned early from deployment speaks to extant voids in soldiers' help seeking or access to needed support services when they most needed assistance. Programs do exist to support families, including ones that address pre/re-deployment 'transition' challenges inherent in the disruption of marital/family continuity (e.g., Family Readiness Groups—FRG, Army Community Services—ACS, Family Advocacy Program—FAP). However, the current variable resourcing, organizational stove-piping, and inconsistency in applying tailored

programs and processes to facilitate the marital reintegration requirements for soldiers and their spouses (particularly for unique AD cohorts—e.g., US Army Special Operations Command (USASOC), Reservists, etc.) in the context of operational missions is of significant current and near-term future concern.

6. **Flawed Model for Behavioral Health Services.** The current model of delivering services for domestic violence (DV), substance abuse (SA), and behavioral health (BH) care prevention and treatment efforts as expressed in Army policy, structure, and resourcing is perceived by experienced active duty medical professionals and consumers (leadership, soldiers and spouses) as flawed and counterproductive thereby discouraging early identification and therapeutic engagement. Involvement with FAP, Alcohol and Substance Abuse Program (ASAP), and/or BH services is perceived to be equated with the risk of potential premature career termination[3].

RECOMMENDATIONS:

1. **Recognize Marital Discord as a Pervasive Factor Impacting Mission.** Safe access to earlier care is needed to prevent progression to more serious dysfunction. Focus groups uniformly endorsed the success of unit chaplains as sources of marital support. The workplace-centric chaplaincy methods of care represent an ideal model for delivery of behavioral health services, as was demonstrated in the Pentagon after the attack on 9/11.[4 5] BH care should be made available for active duty families (particularly for junior enlisted spouses and for children) on-post where they already get the vast majority of their medical care. TRICARE network support also needs to be improved both by increasing the availability of appointments and by instituting reimbursement for marital, family, and abuse counseling.

2. **Commission Study on Impact of PERSTEMPO.** DA/DoD should commission a systematic study of the impact of deployment operational frequency and intensity on the health and welfare of soldiers and their families to definitively address the hypotheses partially supported by this preliminary work. This EPICON developed a significant amount of suggestive data that can assist in structuring such a study. The data suggest that PERSTEMPO and associated family disruptions in the context of variable deployment-redeployment transition programs/FRGs, and distrust of behavioral health care, ASAP, and family advocacy program services is significantly impacting families and may contribute in rare cases to tragedy. Of more systemic significance is that these rare family catastrophes may be a symptom of a wider family wellness problem. An analysis is needed regarding health outcomes, divorce rates, domestic violence, premature attrition, and other health risk behaviors associated with frequent peacekeeping and/or combat deployments, as well as analysis of health care delivery and barriers to treatment. Such analysis would provide more sufficient evidence regarding these important mission-related medical and personnel questions to help guide constructive policy changes.

3. **Re-Energize Deployment Transition Programs.** Current command sponsored deployment ‘transitional’ programs, including FRGs, should be re-evaluated as to

their content, effectiveness, consistency of resources, and how they are tailored to particular units. Transition programs may benefit from the presence of workplace-centric behavioral health professionals acting as consultants in a re-engineered care delivery model.

4. **Re-Engineer To Optimize Delivery of Integrated Behavioral Health Services.** Soldiers and families need proactive, accessible, and career-safe BH care (BH = mental health services + FAP + ASAP). The available evidence supports the need to reengineer our current BH prevention/clinical systems. The challenges in doing so are legion and will require the committed leadership of the Army to overcome predictable entrenched resistance. As presently configured, Army BH programs do not practice basic public health or preventive medicine principles for BH problems:

    - *screening* to treat proactively those most 'at risk' for BH dysfunction
    - *surveillance* for DV, SA and BH dysfunction indicators
    - systematic and integrated BH *data* collection and analysis
    - *accessible* and career "safe" pre-clinical and clinical interventions that are workplace-centric
    - *integrated* BH services delivery for DV, SA, BH dysfunction
    - Single *portal of entry* into BH care system with a common *core evaluation*
    - objective BH *program evaluation*

BH Care Re-Engineering Recommendations

BH Care = FAP + ASAP + MH

NEW FEATURE	RATIONALE
Systematic Screening	To identify & proactively treat those at risk
Single BH data system	Care continuity, integration, efficiency, evaluation
Surveillance-talking/surveys/data bases	Earlier care protects careers/marriages, >readiness
Pre-clinical, workplace-centric focus	Career-safe, promotes access, command-consultation
Integrated BH system--FAP, ASAP, MH	Forward-deployed BH professionals
Single BH professional liaison to units	Chaplain model— relationships/trust develop
Provides preventive& pre-clinical care	Including FRG consultation, etc.
Single portal of entry	Decrease confusion to commanders & soldiers
Single, core BH evaluation	Less redundancy, accurate info, ↓perceived danger
BH care for spouse/children on post	↓ barriers→ ↑care→ ↑ readiness/ ↑well being
TRICARE— improve BH network care	Improve access: earlier care while small problems
Cover marital, family, abuse probs	$ for V-codes→ no severe diagnosis→ earlier care
Address reimbursement levels, probs	Best providers take TRICARE last or not at all

DISCUSSION OF FINDINGS:

FINDING #1: **Statistically Significant Cluster.** Rare events such as homicide, which occurs at roughly a rate of 6 per 100,000 per year in the U.S. overall[6] (or 1/100,000/year for intimate partner homicide)[7] can cluster (aggregate in brief time periods) at times randomly. Although it appears that the overall homicide rate at Fort Bragg over the last 12 months is not significantly different from the national rate, there is no question that the fact that the index cases clustered over two months and all involved intimate partners is very rare. Analyses suggest that this was a statistically significant outbreak, despite limitations in applying statistical tests to such rare events retrospectively. Efforts were made to obtain indirect measures of distress on post by looking at health care utilization records and risk reduction data over time. These data were inconclusive and will require further surveillance. However, it is noteworthy that this EPICON was not able to obtain and develop comparative trends for FAP data at Fort Bragg and the rest of the Army for the surveillance period in question because of: 1) difficulty accessing central FAP data for the study period and interpreting local quarterly data, and 2) concerns about definitional changes in mild DV cases starting in 1999 which may affect background rates of one broad measure of community distress. Regarding the data from the index cases, there is no specific epidemiological link between the individual cases, although the demographics of the cases mirror those in civilian studies.[8] Threatened marital separation/dissolution and perceived imminent familial loss were likely very important psychological etiologic factors in the four soldier index cases.

FINDING #2: **Mefloquine Unlikely Cause of Clustering.** Mefloquine is unlikely to be the cause of this clustering. There was no evidence that mefloquine (Lariam) was prescribed for two of the four active duty index cases ([redacted]—see Appendix C). One of these soldiers had returned from Afghanistan several months prior ([redacted]). He was not prescribed mefloquine, based on electronic pharmacy (CHCS) data, medical records, discussion with unit members, and a negative postmortem toxicology test. Case [redacted] also was not prescribed mefloquine based on the CHCS data, the medical record, and the lack of deployment history in the past year. CHCS data indicated that the two other index cases had been prescribed mefloquine (case [redacted] and case [redacted]—the two soldiers who had deployed most recently to Afghanistan). One of these soldiers (case [redacted]) had mefloquine detected on a postmortem toxicology test. The other soldier is in custody and was not tested as a part of this EPICON effort because of pending civilian prosecution.

For the two cases for whom mefloquine was prescribed, there was no reported history of change in personality or psychosis, per USASOC Surgeon's office, Criminal Investigation Division (CID) records, and data made available from peer/leadership interviews, though direct interview data was not obtained for either one of these soldiers ([redacted]). CHCS data were also reviewed for four other AD suicides occurring among Fort Bragg soldiers since January 2002 and a soldier who had committed homicide in January 2002. None had a history of mefloquine prescription.

Based on focus groups and medical record review of one of the soldiers involved in one of the index cases, one of the concerns raised regarding mefloquine use by active duty personnel at Fort Bragg was the reported inconsistency in the medical documentation and risk communication during the prescription process. This factor, coupled with inconsistent screening of individuals who may be at increased risk for neuro-psychiatric side effects, does not meet prescribing standards according to CDC guidelines[9] or the latest drug company warnings/package inserts[10].

The systemic concerns about routine use of mefloquine among deployed soldiers is beyond the scope of this EPICON's charter, but was addressed by a recent Assistant Secretary of Defense for Health Affairs ASD (HA) response[11] dated 13 September 2002 to a Congressional query regarding the use of mefloquine. This response outlines the current plan to deal with real concerns regarding the safe use of mefloquine among military service members.

During the course of preparing this EPICON Report, the authors became aware that ASD (HA) was already engaged in responding to Congressional queries regarding the safe and appropriate use of mefloquine in deploying service members. Since this systemic-level question is well beyond the scope of the EPICON's Charter, any system-wide recommendations are most appropriately the purview of ASD (HA) and the military services' Surgeons General.

FINDINGS #3: Marital Discord a Major Factor, #4: PERSTEMPO Contributor to Marital Discord, # 5: Re-deployment Transition Program Execution Challenges. The deployment-driven disruption of marital/family dynamics has been and is of significant ongoing concern to DoD and the Army ever since it became clear several decades ago (with the inception of voluntary versus drafted service) that the four DoD services were going to continue to trend towards being predominantly a married force. With the end of the Cold War in the early 1990's, (and subsequent reorientation in mission(s) necessitating ever more frequent deployments by a post-Persian Gulf War downsized force), unit commanders at all levels working collaboratively with their unit chaplains, installation helping agencies, local BH assets, and others, have implemented pre-/post-deployment transition programs, FRGs, and other activities to attempt to mitigate against this well-recognized significant family stressor.

In deployment scenarios where significant numbers of soldiers are deploying simultaneously as units, the pre-/post-deployment preparations generally occur in a fairly thorough and structured way to the benefit of the deploying soldiers and their families. However, current resource constraints mandate that these efforts operate from a general assumption that 'one size fits all', and the resources that are available for these efforts come out of unit/command operational resources and borrowed manpower from other agencies.

Another challenge is that these deployment 'transitional' programs are the responsibility of individual unit commanders and as such there is no formal structured

organizational/institutional oversight that would allow for integration and additional resourcing at an installation level.

Of particular concern regarding the EPICON's three index cases who deployed/re-deployed prior to the subsequent homicide/suicide, was that two of these cases [redacted] involved soldiers who returned early from Afghanistan specifically in response to their requests for emergency leave to address perceived marital distress. The subsequent outcomes after their return speaks to extant voids in soldiers' help seeking or access to needed support services when they most needed assistance. The fact that Fort Bragg is at the forefront of the war in Afghanistan obviously raises valid questions that the recent intimate partner homicides/suicides could in part be related to the stresses of high PERSTEMPO after 9/11, combat/deployment experiences, and/or other factors related to military duty. Although there is no direct evidence proving such a link, data from the focus groups and the research literature support this hypothesis as having some potential validity.

Many of the soldiers who participated in focus groups reported that the pace of current operations is so high that there is not enough time for the soldier to adequately recover before the next deployment. Soldiers reported that even when they return from a deployment, they still don't have adequate down time to spend with the family as they receive additional taskings. Of particular note is how leave is managed at Fort Bragg. Nearly every group of soldiers interviewed from both the USASOC and XVIII ABN Corps, including the First Sergeants and Sergeants Major, reported that soldiers are not infrequently expected to take leave on the weekends and/or during holidays, in part because there is insufficient manpower to support the workload, as well as to avoid the appearance of losing leave that has accumulated above the maximum allowed at the end of the fiscal year.

Regarding published studies, one of the best available studies analyzed data from a large random sample of over 26,000 married active duty Army service members from 1990 to 1994 (95% male). This survey included detailed questions about intimate partner violence during the previous year and was conducted anonymously to encourage honest answers.[12] Self-reported severe aggression (defined as beating up, choking, or using/threatening the spouse with a knife or gun) in the previous year was reported by approximately 4% of the soldiers. There was a small but significant association with deployment and a "dose response" observed with longer deployment being associated with a higher risk of severe spouse aggression. The probability of severe aggression increased 16% to 35% above the baseline rate for deployments ranging from less than 3 months to greater than 6 months. Another study using the same Army database compared with a nationally representative civilian sample who had been given a similar survey found that after adjusting for age, race, and gender - the incidence of severe violence was 2.5 times higher among active duty service members than among civilians[13].

A study conducted among U.S. Army combat arms soldiers deployed on peacekeeping missions to Kosovo showed that the number of adverse experiences in

the operational setting in Kosovo (such as being shot at, seeing dead bodies, handling land mines, etc.) had a direct relationship to interpersonal problems reported on returning home.[14] Getting in physical fights, having serious conflict with family members, threatening or being verbally abusive, or having thoughts of hurting someone were reported significantly more frequently for those exposed to a greater number of adverse peacekeeping experiences. Among soldiers who had had more than 10 adverse operational experiences, 10% reported getting in physical fights, 20% reported threatening someone with physical violence, and 18% reported having serious conflict with family members or friends. Remarkably, this was not an anonymous survey, although it was conducted as part of a research protocol in which the questionnaires were kept separate from the medical record and therefore confidential.

Taken together, the published studies along with EPICON focus groups suggest a link between intimate partner violence and deployment experiences among Army soldiers, and lend biological/epidemiological plausibility to the hypothesis that high PERSTEMPO or other factors related to the current war environment *may be* indirectly related to the recent homicides at Fort Bragg. Focus group interviews conducted as part of this EPICON suggests that the PERSTEMPO, unpredictability of work schedules, lack of sufficient leave/down time, and problems with re-integrating after deployments are having significant adverse effects on the health of some military families. The four recent homicides of Army spouses at Fort Bragg provide an opportunity to examine the larger issues involving the health and support of military families. It may not be just a random coincidence that these tragedies are occurring at a time when PERSTEMPO has increased significantly at Fort Bragg since 9/11.

FINDING #6: Flawed Model for Behavioral Health Services. Although there was known marital distress in all cases, there was no record of any of the index case soldiers accessing BH services prior to these tragedies. EPICON-conducted focus groups of beneficiaries (e.g. soldiers and spouses), 'gatekeepers' (e.g. chaplains and on-post school counselors), commanders, and senior leaders, all consistently conveyed the conviction that engaging FAP, ASAP, or BH services, even if self-referred, is detrimental and often terminal, either directly or indirectly, to a soldier's career. In many cases, 'going downtown' was viewed as the only safe way of accessing professional BH care. Note that the TRICARE benefit does NOT include coverage for marital or family problems (V code diagnoses under DSM-IV) in the absence of diagnosed Axis I illness.[15]

Common to most Army installations, professional BH services are limited at Womack Army Medical Center (WAMC), Fort Bragg for non-active duty beneficiaries. As such, the TRICARE network is the exclusive funded source of BH care for spouses and soldiers' children. There is a documented appearance of a robust civilian BH service TRICARE network. However, soldiers, spouses, DoD school counselors, and WAMC BH providers all claim a paucity of TRICARE network capacity resulting in the inability to obtain timely appointments (particularly for children) or with long waiting times (2-6 months), adding to the feeling of lack of support and isolation that many family members feel.

For soldiers, routine self-referral to installation-based BH services, even in the absence of domestic violence, was typically perceived to be career endangering. These findings are consistent with a 1998 DoD Survey which found that only ~20% of active duty members perceived that it was truly career-safe to engage mental health services[16]. A recent DoD-wide data review[17] just published in one the nation's leading psychiatric journals confirms that 27% of DoD service members seen as an outpatient for any type of behavioral health diagnosis were no longer on active duty 6 months later compared to 9% of those who accessed care for all other medical conditions. These data reflect the perception that engaging BH services (mental health care, FAP, ASAP) have a high probability of resulting in career termination.

Based on the focus groups involving soldiers, spouses and leadership, there is also widespread lack of trust in the FAP, despite the fact that soldiers and spouses readily indicated that at times they do need marital help. Soldiers believe that their careers are over if they use or are referred to FAP. Even spouses admitted that family violence often goes unreported because of the impact that they perceive such reporting can have on the soldier's career and on the long-term health and economic stability of the family. Soldiers and spouses perceive that FAP views Army families as being either healthy or dysfunctional, with no middle ground where a family incident can go unreported/undocumented while the family gets needed help.

Although most expressed reluctance to access BH services because of their career concerns, soldiers and their families experience unique stressors because of these same careers. Focus group members highlighted that the Army stresses families and soldiers by moving (PCS) them, separating (deploying) them, and by exposing soldiers to physical and psychological dangers while their families bear the attendant uncertainties. The medical literature confirms that these latter service-linked trauma /war exposures affect a large portion of the population in clinically significant ways[18] [19].

The EPICON's Focus group interviews highlighted the frustration of being aware of significant needs created by these military-unique stressors, with both BH providers and beneficiaries working and living within a system in which existing BH services are perceived as unsafe to access and/or just not available. Gatekeepers, particularly Chaplains and on-post school counselors, were convinced that there were significant unmet needs that either were not addressed by the Army's services or were subject to the default perception that 'if it's bad enough, they'll find a way to "get help downtown".

DISCUSSION OF RECOMMENDATIONS:

DA /DoD should commission a more formal study to address the hypotheses partially supported by this preliminary work. A systematic study to address the hypotheses raised by this consultation could be conducted as an anonymous survey of soldiers in various operational units on Fort Bragg and other installations, preferably before, during, and post-deployment, but could also start with a cross-sectional survey post-deployment. Factors that could be assessed include the relationship of deployment duration, PERSTEMPO, and combat experiences to depression, anxiety, post-traumatic stress syndromes (i.e. PTSD), alcohol, family violence, physical symptoms, and other health risk behaviors. Positive moderators, such as strong and compassionate leadership, predictable work hours, deployment transition/family readiness programs, and protected leave could also be studied. Expertise to conduct this type of research is available through the Walter Reed Army Institute of Research (WRAIR), the Centers for Disease Control, and other military and civilian organizations. WRAIR has already established collaboration with Centers for Disease Control and would be amenable to organizing such an effort, if there was sufficient interest and DA/local leadership support at Fort Bragg and other selected study installations. This crucial period of current/near-term future war is a very important and opportune time to conduct such a study for the current and future benefit of our Army's mission effectiveness and the welfare of our soldiers and their families**.**

Soldiers and families need earlier, more accessible, and career-safe behavioral health (BH) care. The available evidence supports the need to reengineer our current BH prevention/clinical systems in a way that emphasizes integrated delivery of care and preventive medicine/public health principles.

The recent events at Fort Bragg have raised the level of awareness of these issues on post and provide an opportunity to think "outside the box" with regard to how behavioral health care, alcohol/substance abuse treatment, family advocacy and social work services are delivered, marketed, resourced, and integrated. Re-engineering of behavioral health care delivery should also explore the complex dynamics surrounding the issue and thresholds of mandatory investigation and reporting of possible spousal violence. There are various models of care delivery that can be considered in a re-engineering process. For example, one potential model is to make nearly all outpatient appointments to the various behavioral health care services walk-in—no appointment necessary—episodes of care. Soldiers or commanders who called would simply be given times when the soldier can walk in and wait for an appointment. This is much simpler than attempting to get an appointment through TRICARE or having to determine if the soldier's condition is truly an emergency warranting an urgent evaluation (which can sometimes involve additional time making phone contact with a physician). Another model of behavioral health care delivery which could be considered is to deploy behavioral health resources closer to the units (workplace-centric), which would help to improve communication with commanders and NCOs, improve access to care, provide pre-clinical preventive services, and facilitate support of the primary "gatekeepers" such as chaplains, senior NCOs, company commanders, and commander's programs, such

as Family Readiness Groups. Chaplains can play a particularly important role in the interface between company commanders and senior NCOs and mental health services. In one study in a basic training environment, improving access to care through these methods paradoxically was associated with significantly decreased need for care and decreased mental health workload, probably as a result of empowering the primary gatekeepers (chaplains, etc.) and improving the direct contact between unit commanders and mental health providers.[20] [21] Pre-clinical (primary prevention) models have similarly improved access to career active duty members (enlisted and officers) in the BH response to the Pentagon attack.[22] [23]

Preventive and pre-clinical approaches that cross community and agency boundaries have also been prominent in the innovative approaches practiced by the Army Chaplaincy and promoted by the Office of the Deputy Chief of Staff for Personnel's (ODCSPER) recently re-engineered Army Suicide Prevention Plan. The model of using forward-deployed/workplace-centric personnel such as chaplains and others trained in suicide screening is an example of putting prevention into practice which is needed for the full range of BH difficulties (including domestic violence).

Both focus groups and medical practitioners reported that, for the most part, only active duty soldiers could be seen for BH issues within the direct care system at Fort Bragg. Therefore, short of hiring more BH practitioners, another essential component of making care more accessible would be addressing shortcomings of the TRICARE civilian network for delivering BH care services. Focus group findings validated what many career AD BH professionals have observed: whereas under CHAMPUS the best BH practitioners in the community sought to fill their practices with military beneficiaries, under TRICARE the better practitioners tend to take TRICARE cases as a last resort or not at all because of a minimalistic approach to clinical services reimbursement. Of particular importance is that the current TRICARE benefit does not cover counseling for marital or family dysfunction (including abuse) diagnoses (ie. DSM-IV, V codes); rather it requires documentation of a more serious and even more stigmatizing Axis I psychiatric disorder.

In addition to taking steps to make BH services more accessible, developing more effective primary prevention screening is also important. Recent and emerging studies suggest that there may be ways to target cohorts that are at higher risk for BH dysfunction. For example, large-scale studies have confirmed that cohorts that have experienced early adverse childhood exposures are at higher risk for a range of health risk behaviors.[24] [25] [26] [27] Not everyone in these risk cohorts go on to develop significant problems. However, these same studies underscore that BH dysfunctions tend to cluster in the same individuals and their families (e.g. substance abuse, higher incidence of sexually transmitted diseases, higher incidence of depression, higher incidence of suicidal behaviors, increased mortality, etc).

There is presently no integration of FAP, ASAP, and BH services and databases to make such a primary prevention and early intervention model a reality. FAP, ASAP, and BH delivery systems are segregated and stove-piped up to the DA level; each has

their own professional personnel, clinical records, and data systems which do not typically interact with one another, and which do not maintain good continuity of care over time and across PCS transfers to other installations. These and many other factors argue for an integrated system of BH access, service delivery, record keeping, data collection/analysis, and continuous program evaluation that moves towards seeing these difficulties as an interrelated whole. An integrated, current, and accessible data base could proactively contribute to promoting the social health and readiness of the individual soldier in much the same way that FORSCOM's and TRADOC's Risk Reduction Programs attempt to collate human resource data as a way of attempting to promote social functioning and readiness of military units and the entire military community.

As mentioned in the findings, the Army uniquely stresses soldiers and their families in ways that affect everyone, and yet it is perceived that only those with severe problems are seen by the BH care delivery systems, and that this often ends in career loss. Focus group members expressed the need for a safe middle ground where professional care may be accessed as safely and as readily as are Chaplains. Moving towards such a model makes sense from a clinical standpoint as well. As in other areas of medicine, early care for small problems usually prevents them from growing into larger, more pervasive, and severe problems. Problems that are successfully worked with before they cause collateral social damage have the added benefit of tending to promote the development of individual autonomy, social functioning, and psychological adaptability—key traits underpinning the high functioning expected of the Objective Force soldier.[28] When identified early, many BH difficulties lend themselves to a pre-clinical care where diagnosis, charting, or reporting need not even become issues. Chaplains refer to such proactive work as 'ministry of presence;' and in the still ongoing post 9/11 Pentagon work, it is referred to as 'therapy by walking around.' Forward-deployed BH professionals make it easy for the soldier to access pre-clinical support, for concerned commanders or colleagues to make informal referrals, and for the BH professional to gain a better sense of the contextual stresses facing an entire unit and thus the individuals in it. This more collaborative, less 'zero-defect' model of BH growth-facilitating care for the many (or even most over the course of a 20-year career) in lieu of the present 'career-terminal' clinical care for the overwhelmed few, recognizes that a soldier's social and family functioning is an integral part of his overall professional functioning and career success.

Army Transformation underscores the need for a re-engineered BH system: the Objective Force envisioned will require psychologically adaptable soldiers operating from emotionally sound personal and family platforms. A career-long learning model of ongoing soldier personal and family development in which accessible and collaborative BH care plays a role in promoting the growth of psychological resilience and adaptability, in both the soldier and his family, complements the Objective Force model concept of professional skills development - lifelong learning[29]. The appended reference[30] charts the contribution of a reengineered Army BH to Army Transformation.

References:

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Re-engineered Behavioral Health contributes to Army Transformation

	LEGACY FORCE --present clinic centered system	**OBJECTIVE FORCE** --'Therapy By Walking Around'
Behavioral Health Model	Paternalistic Targets young problem soldiers	Soldier/Family Development… Lifelong Learning
Access to care	Gatekeeper clinical referral	Informal pre-clinical referral = TBWA
Focus	Patient-diagnosis-chart	Function enhancement-no chart
Who needs care	Problem soldiers	Most over a 20yr career/post-deploy/etc
Who recognizes need	Unit	Self/Family/Colleague/~Unit
Perception of who care is for	Serves the Army's needs	Serves the soldier's & family's needs
Career impact	Often 'the last stop'	Safe—protects career
'Who's responsible'	Command	Soldier/medical/command
Population penetration	Low-mostly 1st term enlistees	High—includes career soldiers
Command/medical visibility	Low-mostly 1st term enlistees	High—includes career soldiers
Readiness impact	Low-often too late	High—early help→ avoids larger problems
Soldier/family development	Low-career loss vs opportunity to learn	High—collaborative, **lifelong learning**
Positive collateral impact	Low	High—MVA's, DV**, ETOH, med utiliz
Post-Deployment impact	Low-untreated war-exposures b/c chronic	May prevent PGW type illness & PTSD

* TBWA = Therapy By Walking Around
**DV = Domestic Violence

Appendix A – EPICON's CHARTER

CHARTER 1 August 2002

EPIDEMIOLOGICAL CONSULTATION (EPICON) FOR THE CLUSTERING OF HOMICIDES-SUICIDES AT FORT BRAGG, NORTH CAROLINA
JUNE-JULY 2002

1. ESTABLISHMENT, PURPOSE AND SCOPE.

a. ESTABLISHMENT. The Office of The Surgeon General (OTSG) established the epidemiologic consultation (EPICON). This Charter delineates the EPICON's purpose, membership, and specifies the scope of activities.

b. PURPOSE. The EPICON team will consult to the local medical and line leadership of units at Fort Bragg to assess and provide recommendations to address potential systemic, cultural, and resource-limitation factors which may be related to the recent clustering of homicides and suicides, as well as deployment-related behavioral health issues. Recognizing that deployment behavioral health concerns for service members and their families are not unique to Fort Bragg, the EPICON team will generalize its consultation to address service-wide policies, procedures, and resource requirements which may be constructively informed by their findings and recommendations.

c. SCOPE OF ACTIVITY.

(1) The EPICON team will:

(a) Assess pre- and post-deployment soldier and family education programs, practices, and support/clinical services relative to Service/DoD policies, procedures and requirements.

(b) Organize relevant statistical data for comparative analysis.

(c) Assess the specific data associated with the index cases looking for patterns, contextual factors, organizational dynamics, and medical issues which may have causal and/or contributing associational significance.

(d) Utilize Fort Bragg's index cases as a basis to assess the relevancy and adequacy of the Services' current policies, procedures, and resource requirements.

2. ORGANIZATION.

a. The EPICON team will consist of the following membership:

- Team Leader, Behavioral Health (BH) Consultant, US Army Medical Command (MEDCOM)
- SG's BH Consultants in Psychology, Social Work and Psychiatry
- Chief, Department of BH and Epidemiology, WRAIR
- Chief, Department of Operational Stress, WRAIR
- Representative from Center for Health Promotion and Preventive Medicine (CHPPM)
- Representative from U.S. Army Chief of Chaplains
- Representative from the Deputy Chief of Staff for Personnel (DCSPER)/program manager for the Army's Suicide Prevention Program
- Representative/SME from North Atlantic Regional Medical Command (NARMC)
- Representative/SME from Assistant Secretary of Defense for Health Affairs (ASDHA)
- Representative/SME from Headquarters, Forces Command (FORSCOM)
- Other representatives/SMEs as deemed appropriate by OTSG

b. The EPICON team will interface and coordinate with the local line and medical leadership at Fort Bragg, as well as other echelons of relevant line and policy leadership to accomplish the stated PURPOSE and SCOPE OF ACTIVITY above.

3. PROCEDURES.

a. The EPICON team will initiate their efforts to accomplish its PURPOSE effective the date of this CHARTER's approval, and anticipate a 4-day onsite visit to Fort Bragg, on or about 26 August 2002.

b. An inbrief from the EPICON team will be made available to relevant line/medical leadership the 1st day of the visit. An outbrief to the local line/medical leadership describing preliminary findings and hypotheses under consideration will be provided on 29 August 2002.

c. Access to locally and centrally available relevant data sources (clinical personnel, etc.) will be requested.

d. Interviews with relevant unit/medical leadership will be requested at Fort Bragg, and at higher echelons of line and policy leadership.

4. DELIVERABLES.

a. A preliminary written report of the EPICON's findings and recommendations (after review by USASOC to ensure that no classified information is inadvertently released) will be completed and submitted to OTSG NLT 30 September 2002. The final report's submission date is contingent on completion of any relevant data analysis.

b. Briefings (after review by USASOC to ensure no classified information is inadvertently released) of the EPICON's findings and recommendations to general/flag officers at all appropriate echelons, and ASD(HA) officials will occur as directed by OTSG.

c. No media communications will occur among the EPICON team members without the approval of OTSG.

< original signed >

KENNETH L. FARMER, JR., M.D.
Major General
Deputy Surgeon General

Appendix B - EPICON TEAM MEMBERSHIP:

[redacted], LTC, CH, USA

- Representative/Subject Matter Expert (SME) from U.S. Army Chief of Chaplains

[redacted], LTC, MS, USA

- Research Psychologist, Dept. of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research

[redacted], DSW, MAJ, MS, USA

- Representative/SME from Center for Heath Promotion and Preventive Medicine (CHPPM)

[redacted], PhD, COL, MS, USA

- Clinical Psychology Consultant, Army Medical Department Center and School(AMEDDCandS)

[redacted], M.D., M.P.H.

- Medical Epidemiologist, Division of Violence Prevention, Centers for Disease Control(CDC)

[redacted], M.D., MAJ, MC, USAR

- Representative/SME from U.S. Army Special Operations Command

[redacted], MSW, COL, MC, USA

- Chief, Department of Social Work, Walter Reed Army Medical Center

[redacted], MD, COL, MC, USA

- Chief, Department of Psychiatry and Behavioral Sciences, Division of Neuropsychiatry, Walter Reed Army Institute of Research (WRAIR)

[redacted], MD, LTC, MC, USA

- Representative/SME from North Atlantic Regional Medical Command (NARMC)

[redacted], MD, COL, MC, USA

- Psychiatry Consultant, US Army Medical Command (MEDCOM)

[redacted], DSW, COL, MC, USA

- Social Work Consultant, US Army Medical Command (MEDCOM)

[redacted], LTC, MC, USA

- Representative/SME from Assistant Secretary of Defense for Health Affairs(ASDHA)

[redacted], DSW, COL, MS, USA

- Chief, Department of Social Work, Brooke Army Medical Center(BAMC)

[redacted] M.D.

- Epidemic Intelligence Service Officer, Division of Violence Prevention Centers for Disease Control (CDC)

[redacted], LTC, IN, USA

- Representative from the Deputy Chief of Staff for Personnel (DCSPER) and program manager for the Army's Suicide Prevention Program

[redacted], LTC, MS, USA

- Representative/SME from HQ, DA Family Advocacy Program Manager, Community and Family Support Center (CFSC)

[redacted], COL, CH, USA

- Representative/SME from Headquarters, Forces Command (FORSCOM)

APPENDIX C- EPIDEMIOLOGY, STATISTICAL ANALYSIS and INDEX CASES:

There were three primary epidemiological objectives:

1) Determine if recent events (homicides/suicides) represent a statistically significant outbreak or are consistent with expected rates. This objective stems from the recognition that rare events can sometimes cluster randomly.

2) Determine if recent events have occurred in the context of increases in other measures of distress installation-wide.

3) Identify any clinical, psychosocial, or medical factors that may be associated with the index cases, such as deployment, PERSTEMPO, and use of mefloquine.

EPIDEMIOLOGICAL INVESTIGATION: CASE DEFINITION / DENOMINATORS

Case Definition and Outbreak Period

Index Cases. A case definition was established. Index cases were defined as fatal intimate partner violence that involves an AD/ Reserve/or NG soldier stationed at Fort Bragg, either as alleged perpetrator (4 cases) or victim (1 case) in June or July 2002. Note that only the four cases involving the soldiers as perpetrators were studied in detail.

For comparison, rates of suicide, homicide, and intimate partner homicide-suicide pairs were calculated for Fort Bragg and for the Army population in general and compared with published civilian rates. Particular attention was given to the two-year period leading up to the current events, which included one year before and after September 2001. This was a natural comparison since the events of September 11, 2001 resulted in dramatic changes in the operational tempo resulting in changes to PERSTEMPO. Figure 1 shows the distribution of homicide cases at Fort Bragg over the two-year surveillance period.

Data on homicides and suicides occurring at Fort Bragg was obtained from the Army DSCPER Suicide Prevention Officer and from the CID and casualty offices at Fort Bragg.

Brief Description of Fort Bragg and Calculation of Denominators.

There are approximately 40,000 active duty service members stationed at Fort Bragg. Most soldiers are associated with various units of the XVIII Airborne Corps (representing 29,000-30,000 soldiers). The US Army Special Operations Command (USASOC) represents approximately 6,500 soldiers officially, and Womack Army Medical Center (WAMC) has approximately 700 soldiers. There are other smaller tenant activities, but the numbers quoted above capture the majority of soldiers

stationed on Fort Bragg. In an effort to get a feeling for the PERSTEMPO, the percent of AD soldiers deployed OCONUS was obtained for the XVIII Airborne Corps by month for the two-year reference period. This information was unavailable for other units, but it can be assumed that USASOC units had at least as high (probably much higher) PERSTEMPO during this period. The denominator of assigned personnel is consistently around 40,000 per month. However, the number of personnel deployed at any given period of time fluctuates from month to month. The red line shown on Figure 2 indicates the assigned number of soldiers from the above units minus the estimated number of soldiers deployed OCONUS. There were accurate figures available for the proportion of deployed soldiers from the XVIII Airborne Corps, and these figures were extrapolated to the USASOC units to calculate the estimated post denominator shown in the figures, although it is likely that USASOC had higher rates of deployed soldiers. Among XVIII Airborne Corps soldiers, the proportion deployed OCONUS averaged 3-6% each month from September 00 – November 01. From December 01 – August 02, the proportion deployed OCONUS increased to 8-19%. Thus, the average number of soldiers on post decreased proportionally in the most recent months (line shown on figure 2). These percentages only provide a rough estimate of PERSTEMPO, as they do not reflect the number of different deployments, duration of deployments, or the impact of training cycles that individual soldiers experience.

ANALYSIS OF EACH OBJECTIVE

OBJECTIVE 1. The first objective was to determine if recent homicides/suicides represent a statistically significant outbreak or are consistent with expected rates.

Suicides. Figure 2 shows the number of suicides by month at Fort Bragg over two years, compared with the estimated denominator. The suicide rate among active duty Army personnel stationed at Fort Bragg was approximately 13.5/100,000/year from September 2000-August 2001 and 16.4/100,000/year from September 2001-August 2002 (including the two murder-suicides). This difference does not reflect a statistically significant increase. Although this compares with a civilian suicide rate of 12.3/100,000/year, these figures are not comparable since the Fort Bragg population is predominantly a young male population and males have substantially higher rates of suicide compared with females. In one study of suicide rates among Army personnel from 1990-2000, standardization by age, race, and gender to the civilian population resulted in a 30% lower rate of suicide in the Army compared with the unadjusted official rates reported by the Army (Eaton, Hoge, et. al. unpublished data, WRAIR). Extrapolating these data to Fort Bragg would suggest that the demographically adjusted suicide rate at Fort Bragg is 9.5-11.5 for the two reference years, comparable to the civilian rate.

Homicides Allegedly Perpetrated by Fort Bragg Soldiers. Figure 1 shows the total number of homicides in which Fort Bragg soldiers were either the perpetrator or victim, for a two-year surveillance period. Only one of these involved the Fort Bragg soldier as the victim (August 2002). Between September 2000 and August 2001 there was one

homicide perpetrated by an active duty soldier stationed at Fort Bragg. [redacted] Between September 2001 and August 2002 there were five homicides by Fort Bragg soldiers, all perpetrated against their wives. [redacted] Based on these cases, the homicide offending rate among Fort Bragg soldiers from September 2001 to August 2002 was estimated to be 12.5/100,000/year, compared to 2.5/100,000/year the previous 12-months. Additional data provided by the CID office at Fort Bragg indicated that there were 7 soldiers who perpetrated homicide between January 1997 and July 2000, the 3½ years prior to the surveillance period established for this consultation (rate ~ 5/100,000/year). (Only one of these cases involved an intimate partner.) These rates compare with a homicide-offending rate of 11.7/100,000/year among males and 1.3/100,000/year among females nationally (1999 data)(1). However, direct comparisons with civilian rates are problematic because homicides in the U.S. tend to be concentrated particularly in large urban populations that may not be comparable with the employed military population on Fort Bragg. Data on homicide offender rates Army wide from CID are pending at the time of this report. The rate of deaths due to homicide among active duty military personnel ranges from 2 to 6 per 100,000 per year (1990-1999, DoD Directorate of Information Operations and Reports-DIOR). These are all unadjusted rates.

Statistical Analysis of Homicides. During the one-year period from September 2001 through August 2002, there were five total homicides perpetrated by Fort Bragg soldiers and one involving the soldier as a victim. If we use the male civilian rate of 11.7/100,000/year, despite the problems with this comparison, it does not appear that the rate of 5 cases of homicide perpetration per 40,000 soldiers at Fort Bragg from September 2001 to August 2002 (12.5/100,000/year) is significantly above the civilian rate. However, what is extremely unusual is that all of these cases involved spouses. Intimate partner homicides only account for 11% of all homicides in the U.S. 1) The rate of dying by intimate partner homicide is 0.89/100,000/year for males and 1.43/100,000/year for females (overall 1.15/100,000/year); 2) Based on these expected rates, there should be less than 1 case of intimate partner homicide involving a soldier as offender every two years at Fort Bragg, and in fact the observed rate over the 4½ years from January 1997 through August 2001 was much less than this. According to the Fort Bragg CID office, there was only 1 case of intimate partner homicide involving the soldier as alleged perpetrator (and two others involving the soldier as a victim) during this 4½-year period (rate ~ 0.6/100,000/year). Given a baseline rate of no more than 1 case every two years in a population the size of Fort Bragg, then 5 cases over the last 12 months would be significantly above the norm ($p<.001$, Poisson rare event vs. standard); 3) The other unusual feature was the fact that the cases did not distribute randomly throughout the year, but appeared to cluster during a two-month period. Out of the six total homicides perpetrated by soldiers during the 24-month surveillance

period, four of them clustered during June and July 2002 (probability of this cluster: p=0.026, Scan Statistic for clustering). 4) If all homicide cases back to January 1997 are included, then the probability of a cluster of 4 over two months is 0.054. Considering only the intimate partner homicides back to January 1997, then the clustering over two months has a probability of <0.001.

Intimate Partner Homicides Combined with Suicide. Homicide combined with suicide is exceedingly rare, estimated to occur at a rate of 0.2-0.3 per 100,000 per year in the civilian population (5). Between 1999 and 2001 there were 9 cases Army-wide involving AD soldiers who killed their wives or girlfriends and then killed themselves, giving a baseline rate of approximately 0.6/100,000/ year (data provided by Army DSCPER Suicide Prevention Officer, source of data was CID electronic reports). None of these cases clustered by post. The higher rate in the Army compared with the published rate in the general civilian population probably reflects the demographic differences of the Army (young adult males) as well as inaccuracies in calculating the rate of such a rare event. Based on the expected rate of 0.6/100,000/year (the more conservative approach), even 2 cases at Fort Bragg in one year has a statistically low probability (Poisson, p=.02), and the probability of 2 or more cases occurring in a two month period is p<.001.

OBJECTIVE 2. Determine if recent events have occurred in the context of increases in other measures of distress installation-wide.

In an effort to determine if the recent events were occurring in the context of any other indicators of mental health distress installation-wide, rates of outpatient and inpatient mental health care utilization were calculated by month over the two years using the electronic ambulatory and inpatient data records. The rate of psychiatric hospitalization among active duty Army soldiers varied between 0.3 and 0.9/ 1000 soldiers per month with no clear trend over the two years (Figure 3). Regarding ambulatory behavioral health care use for mental disorder diagnoses (ICD-9 290-319) to all behavioral health care clinics, for every 1000 soldiers stationed at Fort Bragg, approximately 6-10 individual soldiers received one or more visits to behavioral health care clinics each month, and this rate remained relatively level over the two year period (Figure 4). Both of these rates are comparable to mental health care rates for the rest of the military (6).

In summary, health care utilization data provide potentially useful sources of indirect measures of distress on post. However it is difficult to draw firm conclusions from these data, and it will be important to continue to assess trends in these indices over the next several months. One clearly observable trend was the change in post population size related to a higher proportion of soldiers deploying since December 2001 (Figure 2), a indication of the increase in PERSTEMPO.

OBJECTIVE 3. Identify any clinical, psychosocial, environmental, or medical factors that may be associated with these cases.

To address this objective, information about each of the index cases were obtained through a briefing by CID and local law enforcement authorities, as well as medical records, CHCS, redacted copies of the Serious Incident Review Boards (SIRB), and other information provided by the units. The psychological autopsies on the two cases that involved suicide (cases 1 and 2) were also reviewed. Of note was that all of the index cases came from different units from USASOC and XVIII Airborne Corps and did not know one another. All of the homicides occurred in off-post residences. Regarding the likelihood of "copy-cat" behavior resulting from the sensational publicity, this is extremely difficult to study. Although the national media attention did not occur until late July and early August, there was local media coverage in Fayetteville shortly after the first murder-suicide on 6/11/02.

Description of Each of the Index Cases.

Homicide-Suicides:

Case 1. Date of incident: [redacted] Type of incident: [redacted]

Case 2. Date of incident: [redacted]. Type of incident: [redacted]

Homicides:

Case 3. Date of incident: [redacted]. Type of incident: [redacted]

Case 4. Date of incident: [redacted]. Type of incident: [redacted]

Additional Index Case. There was one additional highly publicized case that is distinct from the above cases because the victim was the active duty soldier (an AGR MAJ working at USASOC) shot in his home on July 23, 2002. The wife and 15-year old daughter are currently in custody facing murder and conspiracy charges.

Comment on Index Cases. Overall the demographics of the index cases are consistent with the literature on severe intimate partner violence and murder-suicide (2,5). The perpetrator is usually male, young to middle age, in a long-term relationship with the victim. Most of these cases involved marital discord and threatened or recent separation, which is also consistent with the literature. Although there was no clear evidence of past or present psychiatric problems, alcohol/ substance abuse, or a history of family violence we relied primarily on the briefings by CID and civilian law enforcement, as well as psychological autopsies completed on two of the cases. The information may not be complete. Regarding deployment histories, three of the soldiers had deployed overseas (Afghanistan), including one who had returned 2 days before the event, one who had returned ~2 months prior, and one greater than six months prior. Two of the soldiers who deployed to Afghanistan returned early due to their

marital problems. The level of combat experience was not known to any of the sources interviewed by this team.

Mefloquine. Regarding mefloquine, Table 1 shows the sources of data accessed to determine if any of the index cases had been prescribed mefloquine. [redacted] For the two cases who had been prescribed mefloquine, there was no reported history of change in personality or psychosis, per USASOC surgeon's office and CID records. However, interviews were not conducted with family members of one of the index cases who is in civilian legal custody. CHCS records were also reviewed for 4 other suicides occurring among Fort Bragg soldiers since January 2002 and the soldier who had committed homicide in January 2002. None had a history of mefloquine prescription.

References for Appendix C:

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Table 1. Data on Mefloquine for four index cases:

	[redacted]					
Case 1	[redacted]					
Case 2	[redacted]					
Case 3	[redacted]					
Case 4	[redacted]					

* [redacted]

Figure 1.

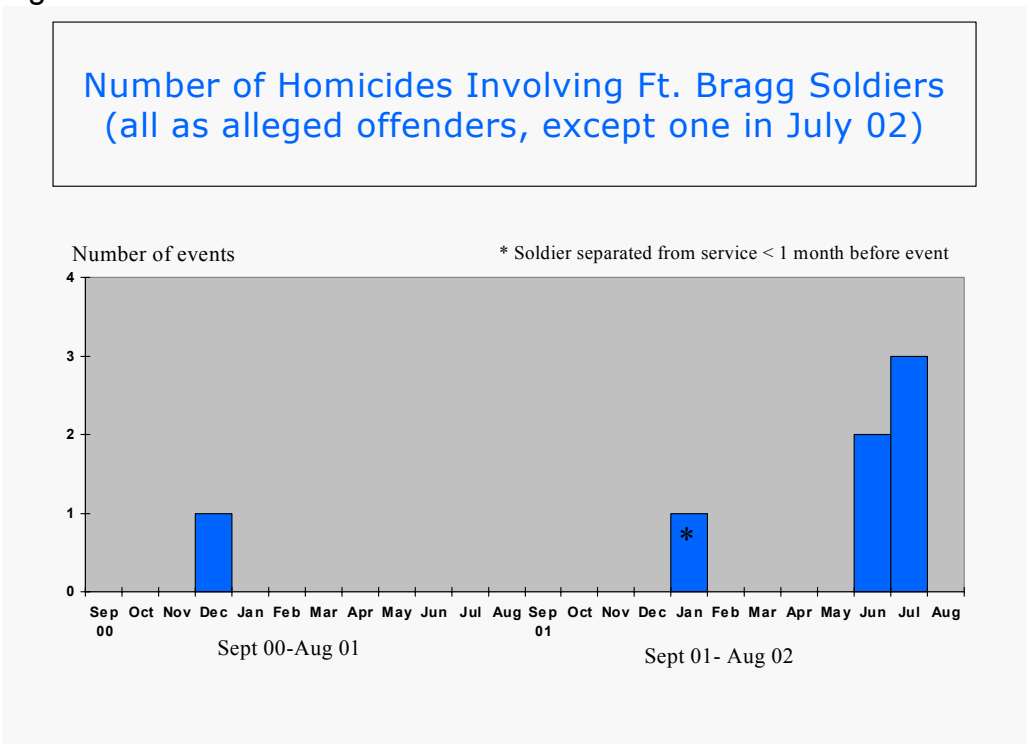


Figure 2.

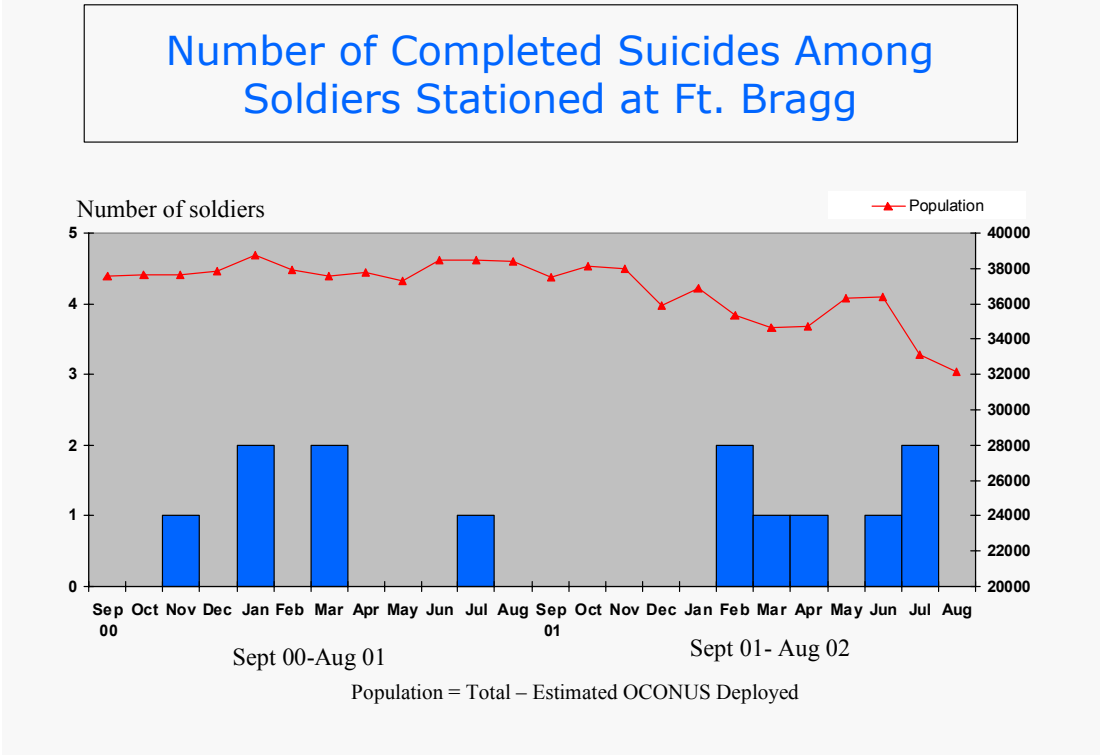


Figure 3.

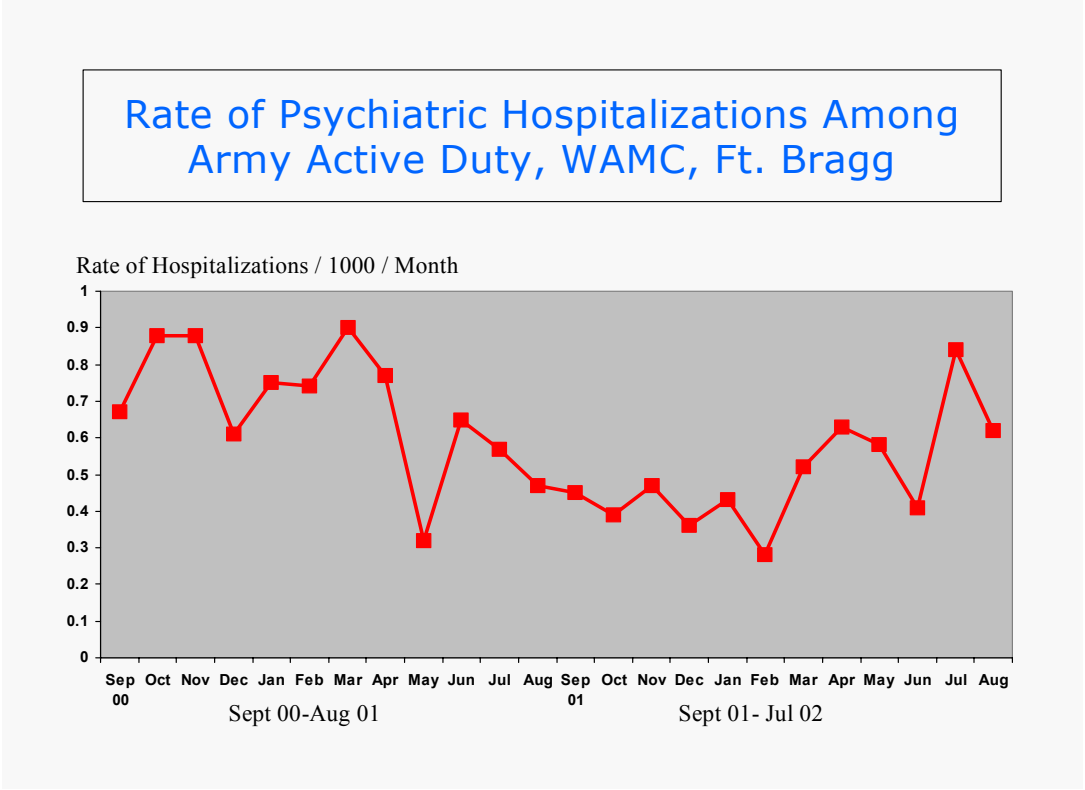
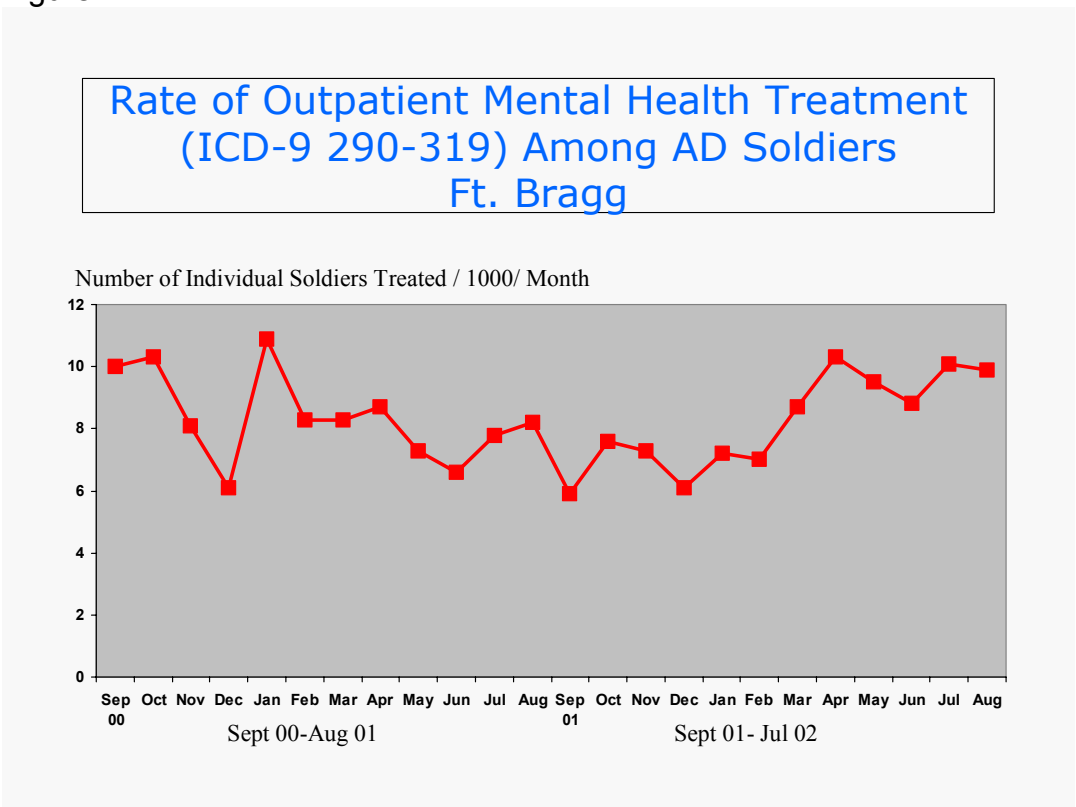


Figure 4.



APPENDIX D: SUMMARY OF EPICON FOCUS GROUP INTERVIEWS

INTRODUCTION

Small group interviews with representative soldier, leadership samples from XVIII ABN Corps, USASOC, Department of Defense Dependent School (DoDDS) counselors, and spouses were conducted to obtain user level perspectives on operational tempo (PERSTEMPO), behavioral health services, and organization/installation support. The purpose of the interviews was to address systemic, cultural, social, and psychological factors that exist at Fort Bragg that might have had some bearing on the index cases.

APPROACH

Focus Groups. Five interview teams, consisting of at least two EPICON team members, conducted all interviews. Thirteen focus group interviews were conducted with the following group composition from the USASOC and XVIII ABN Corps Commands:

USASOC

a. Junior enlisted
b. Noncommissioned officers
c. Medics
d. First Sergeants and Sergeants Major
e. Captain and Major commanders
f. Battalion/Brigade Commanders
g. Spouses

XVIII Airborne Corps

h. Junior enlisted
i. Noncommissioned officers
j. Medics
k. First Sergeants and Sergeants Major
l. Captain commanders
m. Battalion/Brigade Commanders
n. Spouses

In addition to the above group interviews, separate interviews were also conducted with chaplains and chaplain assistants and with DoDDS counselors.

Themes/Questions. Prior to all interviews, key themes and specific questions were determined that every EPICON interview team would attempt to address. In many instances, questions would not be specifically asked, if the issue was brought up spontaneously and discussed without the interviewer directly asking the question. In

some instances, the time allotted for the interview would expire before all questions could be asked and discussed.

Although the questions and themes varied depending on the specific group, there was considerable overlap. Below are the specific themes and questions addressed for each of the focus groups.

For the brigade and battalion Commanders and the Commanders in the rank of major and captain, the interview focused on the following themes: Perceptions of how PERSTEMPO is affecting soldiers and families. How are they adjusting? What is working well? What is not working well? How are deployments affecting the well being of soldiers? What are leadership perceptions of behavioral health care? Interview questions included: (1) How is the pace of operations affecting units, soldiers and families? Has it been different during your time at Fort Bragg? If so, how has it been different? (2) What have you been doing to meet these challenges of high PERSTEMPO? For example, what do you do to prepare families for deployments or long training exercises? Do you think these efforts are working? (3) What else do you think could be done to address this high pace of operations? (4) How have the events since 11 SEP affected the PERSTEMPO of your unit? (5) How have deployments impacted the soldiers and families? (6) If a soldier seeks help through one of the many Army services, such as FAP, marital counseling, anger management, is your perception of that soldier affected? (7) Tell me about your understanding of confidentiality if a soldier seeks behavioral health care. (8) If a member of your family needed behavioral health care, how would they obtain it? (9) What is important for us to know to bring to the attention of policy makers?

For Sergeants Major/First Sergeants, NCOs, medics, and junior enlisted soldiers, the interviews focused on the following themes: Perceptions of how PERSTEMPO is affecting soldiers and families. How are they adjusting? What is working well? What is not working well? How are deployments affecting the well being of soldiers? What are soldiers and units doing to adapt to deployments and the high PERSTEMPO? Interview questions included: (1) How is the pace of operations affecting the readiness levels of units, soldiers and families? (2) What is being done to prepare soldiers and families for separations due to deployments and long training exercises? Do you think these efforts are working? What else could or should be done? (3) What do you do to prepare your family for when you will be away due to deployments or training exercises? (4) How do you think the deployments are affecting family relationships? (5) How do you think the deployments are affecting the soldiers? (6) If a soldier seeks help through one of the many Army services, such as FAP, marital counseling, anger management, is your perception of that soldier affected? (7) Tell me about your understanding of confidentiality, if a soldier seeks behavioral health care. (8) If you or a member of your family is having personal problems, how would you access behavioral health care? (9) What is important for us to know to bring to the attention of policy makers?

For spouses, the interviews focused on the following themes: Perceptions of how PERSTEMPO is affecting families and children. How are families and children adjusting? What is working well? What isn't working well? What can be improved? Specific questions for the spouses included: (1) If you live on Fort Bragg and were a victim of domestic violence, who would you contact and/or where would you go for help? (2) If you live off-post and were a victim of domestic violence, whom would you contact and where would you go for help? (3) If you had a personal or family crisis, which you could not resolve, where would you go for help or assistance? (4) Are you aware of the family support services and programs available at Fort Bragg? (5) If you are aware of the family support services on-post, please provide two reasons why you would or would not use these services? (6) Are you aware of the family support services offered in the off-post community where you reside? (7) If you are aware of these services, please provide two reasons why you would or would not use these services. (8) What are three changes you would like to see in the family support services offered at Fort Bragg?

For the DoDDS Counselors, the interviews addressed the following themes: Perceptions of how PERSTEMPO is affecting family members especially children and adolescents. How are students adjusting? What is working well? What isn't working well? Specific questions for the counselors included: (1) What percentage of your students have parents who are either currently deployed or have deployed more than twice in the past year? (2) Describe any changes you have seen in student behavior, which you attribute to changes in the pace of military activities at Fort Bragg. How does it compare to other posts where you have been? (3) What are your students saying that suggests to you that they are or are not coping well with events in the world today to include the recent publicity concerning events at Fort Bragg? (4) If you have a student who needs professional assistance with personal problems, how does the health care system respond? (5) Do you think that your students believe that they have access to someone who will protect their right to privacy? (6) What is important for us to know to bring to the attention of policy makers?

Procedures. All interviews began with the members of the EPICON interview team introducing themselves and describing the purpose and objective of the interviews. Confidentiality and anonymity were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the group members were recorded. For all of the interviews, whenever appropriate, attempts were made to tabulate (i.e., quantify) the responses to questions. All interviews lasted approximately 90 min.

RESULTS

USASOC Junior Enlisted

The USASOC junior enlisted soldiers reported not having enough time to recover after deploying. These soldiers further reported not having the opportunity to take leave after returning from a deployment. They also reported that they were often told to "burn" leave by officially taking leave, but still coming in and working. The soldiers felt that the leadership didn't recognize how hard they were working. Regarding deployment preparation, these soldiers reported that the information about the deployment, such as when they were leaving, was constantly changing, which made making family plans very difficult. These soldiers stated that PERSTEMPO is adversely impacting the family. Also, these soldiers stated that their expenses while deployed exceed the amount they are reimbursed. These soldiers perceived that there is no such thing as confidentiality when a soldier uses the behavioral health services and that stigma is a real concern.

USASOC NCOs

This group consisted of 14 USASOC NCOs. There were 12 males and two females. The two females were married to other soldiers. The ranks for this group ranged from E-5 to E-8, with 10 being either an E-6 or E-7. The median number of years in the military was 12 years. The median number of years married was 7. These NCOs reported that PERSTEMPO is stressing the family and that there is not enough time to recover and refit after deploying. These NCOs also reported that when they return from a deployment that they are not given the time they were promised to spend with their families. These NCOs reported that many of the spouses were taking prescribed medications to deal with the stress. These NCOs reported that instead of getting to spend time with their families when they return, they sometimes have to perform taskings that seem mundane and further interfere with their process of re-integration. The leave system was also reported to not be working, as soldiers are not able to take the leave they are promised. These NCOs also reported that there is conflict with their spouses around the time of deployments and that their family readjustment process is never completed due to the short suspense timing of their next upcoming mission. They reported that this takes its toll on the family. They reported that the PERSTEMPO hurts their opportunities for education. These NCOs also reported that their deployment expenses are sometimes not sufficiently reimbursed, resulting in financial hardships. These NCOs reported that they wouldn't use the Army mental health services out of fear that it would hurt their career. Instead, they try to handle all problems with the unit.

USASOC Medics

This group of USASOC Medics consisted of 16 males, with the following ranks: two E-5s, 9 E-6s, and 5 E-7s. Fourteen of the medics were married. Eight of them had combat experience. These USASOC medics blamed the PERSTEMPO (i.e., the constant family separations, with little respite) for the many of the marital and family problems. All but one of the married medics in this group reported having marital problems. These NCOs reported that the wives were stressed and angry. Infidelity was reported to be a big problem that is hurting many marriages. This group of medics also stated that the policies on reintegration and post-deployment leave are often not followed due to the preparation for the next mission. These medics were concerned that the leaders keep raising the bar in order to stand out for promotion, and that this occurs at the expense of the soldier.

USASOC First Sergeants and Sergeants Major

The First Sergeants and Sergeants Major group consisted of 6 male soldiers. Their years in service ranged from 19 years to >25 years. Five of these NCOs were currently married. For two of these NCOs, it was their first marriage; for another it was his second; two others were on their third or fourth. The other NCO was divorced and had not remarried. The number of years they had been at Fort Bragg ranged from 12 to 25 years. This USASOC group of senior NCOs said that there is little or no time for families. Leave is either not being given or adequately used. The high PERSTEMPO creates more demand on home-stationed soldiers for taskings. They also stated that the system to help soldiers works against them. Specifically, soldiers won't use mental health services because it is a career ender. They also reported that there is a lack of confidentiality when using these services. This group of senior NCOs also reported that there is stress from a lack of planning that results from last minute changes. This group also stated that mission readiness is disrupted because of soldier concerns about the family.

USASOC Captains and Majors

The focus group with USASOC captains and majors included 8 males. Five were majors and three were captains. There reported number of years in the military ranged from 3 to 14 years. The number of years they have been at Fort Bragg ranged from 3 to 14 years. Seven of the eight were married, with the median number of children being 2. This group of officers stated that the PERSTEMPO was great and that they loved the real-world missions. They did state that the change in tempo does undermine trust and confidence in the leaders. Red cycle taskings also increase the stress level. They were also concerned that the rest of the Army has not shifted from the peacetime mentality to the near-wartime footing that they were on. These two modes of operating clash with organization of training, red-cycle (garrison) tasks, etc. The larger bureaucracy is not used to and has difficulty responding to fluid changes. This group stated that minor or temporary problems or problems that don't impugn on the character of the soldier are

ok, but that they don't have time for long-term problems. This group also stated that the FAP is biased against the soldier. This group was very upset with the mental health services at Fort Bragg, including both the USASOC and Womack Army Medical Center (WAMC) mental health support. Issues raised included lack of confidentiality, difficulty getting appointments, and the impact on the soldier's career.

USASOC Brigade and Battalion Commanders

There were 8 USASOC battalion commanders in this focus group. Their time in service ranged from 16 to 23 years. Eight were married and one was divorced. This group of battalion commanders believes that they are doing well based on both informal and formal evaluations. These commanders also stated that the Army does have a set of quality, comprehensive programs. But they also believe that those who need the services the most don't get it or wait until it's too late because of stigma, confidentiality issues, and fear about the impact on the soldier's career. This group was also felt they were not provided with the guidance, training, and resources to run Family Readiness Groups (FRG) effectively. These commanders also reported that when there are problems with domestic violence the only viable option to soldiers is to seek counseling services off post, because of the impact that this had on the soldier's career. Finally, they were concerned that behavioral health programs, FAP, and alcohol treatment services do not support commanders, and that there is a lack of outreach to the units.

XVIII ABN Corps Junior Enlisted.

The junior enlisted soldiers form the XVIII ABN Corps consisted of 23 junior enlisted soldiers in the rank of specialist to private. There were 18 male and 4 female soldiers in the group. Fourteen of the soldiers were married. These soldiers believed that deployments were adversely impacting marital relationships. This group reported that family emergencies and family issues are often considered not important. This group also reported that opportunities to take leave are not sufficient. Lack of information about upcoming deployments was straining relationships. These soldiers also reported that there is negative stigma to using mental health services and that confidentiality is poor.

XVIII ABN Corps NCOs

There were 20 NCOs from the XVIII ABN Corps in this group. Seventeen were males and three were females. Their ranks ranged from sergeant to sergeant first class. Their years in the military ranged from 4 to over 20. Some of these NCOs recently arrived at Fort Bragg, while others have been at Fort Bragg for over 10 years. Fourteen of these NCOs were married, 6 were single, and one was divorced. These NCOs reported that PERSTEMPO is reducing morale. They also stated that younger soldiers lack basic coping skills. There was the perception that the reduced time spent with the family due to the high PERSTEMPO is worsened by inefficient planning and focus. Training schedules are constantly changed and therefore provide soldiers with

no opportunity to plan their individual time and family time. These NCOs said that young spouses are less willing to support the unit the more time the unit takes the soldier away from the family. The perceptions of behavioral health care utilization varied. Some group members stated that they would respect soldiers who self-referred for behavioral health services. Others stated that their perception of that individual would likely change, with a sense that the soldier might need special support and consideration. Group members reported that overall access to medical services across the board is difficult, especially for family members. They reported that clinicians who are listed as TRICARE providers often do not accept the TRICARE system, or that waiting time for appointments can be on the order of several months.

XVIII ABN Corps Medics

This group consisted of 14 medics from the XVIII ABN Corps. Eleven were males and 3 were females. Their ranks ranged from private first class to master sergeant. Their years of Army service ranged from 1 to 20 years. Six of these medics were married, seven were single, and one was divorced. These soldiers reported that high PERSTEMPO was having a negative impact on families; soldiers have less and less time to deal with family/personal issues. Junior soldiers are not prepared for pace in infantry units, especially now with the rapid pace of deployments and multiple deployments for one individual in a short period of time. Units have less people now, but more taskings. The training schedule is constantly changing, at times with no work until 15:00 and then the unit required to work overtime. Family time is always listed on the training schedule, but often is not granted. There is a perception that soldiers are given little or no appreciation for their hard work. At times it is difficult for soldiers to access mental health services, especially for self-referrals. There is a perception of little to no confidentiality at unit for mental health services, in part because no services are available after working hours. In addition, attendance at programs such as stress or anger management is limited because classes generally are held only during working hours.

XVIII ABN Corps First Sergeants and Sergeants Major

There were 16 First Sergeants and Sergeants Major assigned to XVIII ABN Corps in this group. Fifteen were males and one was a female. Their number of years of service in the Army ranged from 15 to over 20 years. The number of years that have been assigned to Fort Bragg ranged from 2 to >15 years. Twelve were married and 4 were either single or divorced. This group of senior NCOs reported that the high PERSTEMPO is causing low morale and soldier burnout. This high PERSTEMPO makes it difficult to train junior leaders and for soldiers to take leave. Red cycle taskings also reduce the opportunity for soldiers to take leave. Families are negatively impacted from the high PERSTEMPO because the soldier is seldom home. This high PERSTEMPO reduces the spouses' willingness to participate in FRGs. This group also believes that behavioral health care needs are met too slowly or too late, and there is significant stigma. Some 1SGT/SGM's described situations in which they were told

soldiers would need to wait 2 – 3 months before an opening for a counseling or anger management appointment would be available. Other 1SGT/SGM's described a quick response in emergency situations, but reported frustration at the return of soldiers following evaluation for on-going unit watch, which further stressed resources in the unit.

XVIII ABN Corps Company Commanders

There were 17 Company Commanders assigned to the XVIII ABN Corps in this focus group. Fifteen were captains and two were first lieutenants. Thirteen were males and four were females. Their years of service ranged from 3 to 13 years. Twelve were married and 5 were single. This group of commanders reported that the high PERSTEMPO is having significant impact on families, and that soldiers are "getting hammered" by various red cycle tasks. They believe that there needs to be emphasis on FRGs, and that participation rates are very low. They also reported that there is no confidentiality when soldiers use the mental health services, and that the stigma of using them will hurt their career. These commanders reported that they themselves are reluctant to refer soldiers to installation support programs because of the adverse impact that it can have on their careers.

XVIII ABN Corps Brigade and Battalion Commanders

There were eleven battalion commanders in this group, with one major representing his battalion commander who could not attend. All were male. Their years of service ranged from 13 to 25 years. Their time at Fort Bragg ranged from 2 months to 25 years. All were married, with their time married ranging from 9 to 24 years. This group of commanders reported that there are unnecessary training exercises. Further, they believe that duties such as post guard duty and maintenance should be contracted out, since soldiers are already maximally stressed with collateral duties. These commanders said that they don't think any less of a soldier who seeks help for personal problems. However, one commander did add that real "warriors" don't seek help no matter how much commanders encourage their troops to do so. This group also believes that junior enlisted soldiers are more likely to come forward than are NCOs. Chaplains are viewed as a critical resource that needs to be better supported.

DoDDS Counselors, Fort Bragg

This focus group consisted of DoDDS Counselors who worked at the schools located on Fort Bragg. Of the twelve counselors in this group, 9 were females and 3 were males. The DoDDS counselors estimate that nearly a third of children have some type of behavioral, learning, or mental health problem. They also reported that access to mental health care was virtually non-existent for children, and was viewed as the number one priority. They reported that child psychiatrists are booked several months in advance, and other therapists that treat children also take two months to get appointments. Although TRICARE reports that services are available, when parents call the numbers provided by TRICARE they are either told the therapist or psychiatrist

is no longer available or is only taking a limited number of TRICARE clients. They also believe that parents are often afraid to ask for help for fear of the request negatively affecting the soldiers' career. The DoDDS counselors also noted that deployments disrupt the child's routine, which is compounded by the reported observation that due to PCS moves, and deployments (which sometimes results in children being sent to live with grandparents/other relatives) a large percentage of the student population changes each year.

USASOC Spouses

There were 7 spouses of USASOC soldiers and officers in this group. All were female. The ranks of their husbands included two officers (COL and MAJ), three senior NCOs (two SGMs and one SFC), and two junior soldiers (SGT and SPC). There were at least 6 different units represented in this group. The USASOC spouses felt the orientation/sponsorship program was inconsistent. All the spouses thought that there should be mandatory spouse orientation and indoctrination to unit/installation support services. The spouses reported that the installation family support programs are not working well. The USASOC spouses also felt there was no support connection between the senior spouses to the junior spouses. The spouses of the junior enlisted reported that many spouses encourage other spouses to do things that don't help the marriage when soldiers are deployed. All the spouses acknowledged their own reluctance to use FAP as an option for seeking assistance due to the stigma associated with FAP and due to the mandatory investigation and disposition process that may result in adverse consequences, not only for the soldier, but also for the economic stability of the family. Although there was appreciation of some of the FRG and AER support services, many spouses felt that they did not know how to adequately access services, and there were mixed perceptions on their usefulness. The spouses also expressed the need for an early intervention program that prevents the escalation of marital/family abuse that didn't result in formalized reporting. This group of spouses reported that it takes 6-8 weeks to get an appointment with a mental health provider through TRICARE.

XVIII ABN Corps Spouses

Two separate focus groups were conducted with spouses whose soldier was assigned to the XVIII ABN Corps. One of these groups consisted of five spouses, while the other consisted of 11 spouses. All of the spouses were females, with one spouse being prior military. There were at least six different units represented in this group. Nine officer spouses and seven enlisted spouses were in the group. Years in the Army ranged from 1 to 25 years. Years at Fort Bragg ranged from 2 months to 6 years. Years married ranged from 1 to 25 years. For the group of 11 spouses, ten had a least one child, with the median for both groups being 2 children. Three of the 16 spouses lived on post. According to these spouses both they and soldiers are "stressed out." PERSTEMPO is considered a major source of family problems. Several spouses reported taking medication for the first time in their lives in order to deal with the stress that exists at Fort Bragg. Much more work with service members and families is

needed regarding pre-deployment, deployment and post deployment dynamics. Spouses expressed a very low sense of support from military community. There are major concerns about awareness of and access to resources, on and off post, and complaints of poor customer service at on-post agencies. FRGs are not considered particularly useful/effective in their current form. Lack of confidentiality was also voiced as a concern. Chaplains, friends and family are primary points of contact regarding problems, although some spouses even voiced concern over using the uniformed chaplains.

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